

# MEDICAL CLAIM FORM

## KCDRB Form 10C

### LEOFF-1 Assessment of Need for Home Health Care

Please submit this form directly to your physician. After your physician has completed this form, submit it along with Form 10B to your home care provider. After your home care provider has completed Form 10B, submit Form 10A along with Form 10B and Form 10C directly to your LEOFF-1 employer. If you have questions, call the King County Disability Retirement Board at 206-263-6394, or 206-684-1556 (call center).

#### **This form to be completed by prescribing physician.**

(Dictate for typing or print ONLY.)

Name of patient: \_\_\_\_\_

Prescribing physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Prescribing physician street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Diagnosis upon admission to home health care: \_\_\_\_\_

History of illness/condition leading up to home health care: \_\_\_\_\_

Patient's prognosis for recovery: \_\_\_\_\_

Current level of functioning: \_\_\_\_\_

Current medications (please attach printed list to include name, dosage, frequency: \_\_\_\_\_

Other providers involved in patient's health care: \_\_\_\_\_

What treatment services have been prescribed--physical therapy, speech therapy, etc.? Attach treatment plans for each service (required.)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Prescribing physician

**The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board - your privacy over the Internet cannot be guaranteed.**